

NOV. 19. 2014 4:34PM HOLSTON MANOR  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1339-INT P. 411/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

45th 12/06/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2014
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NAME OF PROVIDER OR SUPPLIER

HOLSTON MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

3641 MEMORIAL BLVD

KINGSPORT, TN 37664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	<p>A recertification survey and complaint investigation #34071 and #34208, were completed on October 20, 2014, through October 22, 2014 at Holston Manor. No deficiencies were cited related to complaint investigation #34208. Deficiencies were cited related to complaint investigation #34071 under 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  HOLSTON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664	

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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon medical record review, review of a facility investigation, and interview, the facility failed to immediately notify the family and physician of an fall during transfer with a mechanical lift for one resident (#118) of thirty-eight residents reviewed.</p> <p>The findings included:</p> <p>Resident #118 was admitted to the facility on October 15, 2012, with diagnoses including Senile Dementia, Psychosis, Diabetes with Neuropathy, Congestive Heart Failure, and Stroke Syndrome with Left Sided Hemiparesis.</p> <p>Medical record review of the quarterly Minimum Data Set assessment dated June 6, 2014, revealed the resident scored three of fifteen on the Brief Interview for Mental Status, indicating low cognitive abilities; and totally dependent for bed mobility, toileting, and bathing.</p> <p>Medical record review of the Care Plan dated June 5, 2014, revealed: "Problem...Left Sided Hemiplegia R/T [related to] Previous CVA [cerebral vascular accident]...Resident will be transferred by [mechanical lift] with assist of two."</p> <p>Medical record review of a Nurse's Note dated June 6, 2014, at 6:30 p.m., revealed, "Throughout day resident frequently c/o [complained of] L [left]</p>	F 157	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p><u>F 157</u></p> <ol style="list-style-type: none"> <li>1. Nurse that completed report for Resident #118 and Risk Manager that investigated are no longer employed at facility.</li> <li>2. All residents have the potential to be affected by the same deficient practice. All incident reports will be reviewed in clinical meeting to ensure that notification to family and physician was completed timely.</li> <li>3. Licensed Staff will be in-serviced on notification of responsible parties and physicians regarding unexpected events and/or change in status by the Risk Manager and/or Director of Nursing by November 28, 2014. Education regarding Notification of responsible parties and physicians for unexpected events and/or change in status will continue to be provided to licensed staff during orientation.</li> <li>4. Risk Manager will continue to review all incidents reports in clinical meeting for notification to responsible parties and physician. Director of Nursing and/or Assistant Director of Nursing will audit 5 incident reports per week x 4 weeks to ensure timely notification to responsible party and physician. The Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.</li> </ol>	<p>7/7/14</p> <p>12/6/14</p> <p>11/28/14</p> <p>12/6/14</p>

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F 157	Continued From page 2 arm pain...NP [Nurse Practitioner] in house new orders received...daughter in house notified..."  Review of a facility investigation dated June 9, 2014, revealed the investigation had been completed by the Risk Manager Registered Nurse for a fall on June 5, 2014, involving resident #118. Review revealed the physician and the family were notified of the fall during transfer on June 6, 2014.  Interview with the Director of Nursing (DON) on October 22, 2014, at 10:00 a.m., in the DON's office, confirmed the family and physician had not been notified of the fall during transfer with a mechanical lift on June 5, 2014, involving resident #118 in a timely manner.	F 157		
F 241 SS=D	C/O #34071 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide dignity for one (#192) of thirty-eight residents reviewed.  The findings included:  Resident #192 was re-admitted on April 7, 2014, with diagnoses including Jejunal Intussusception	F 241		

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F 241	<p>Continued From page 3 (collapse of the small intestine), Diarrhea, Dementia, Schizophrenia with Paranoia, and Gastric Esophageal Reflux Disease.</p> <p>Observation on October 20, 2014, at 1:45 p.m., in the resident's room, revealed the resident was sitting in the wheelchair near the doorway, eating breakfast, with no pants on, and the legs exposed. Continued observation revealed a pair of pants lying on the floor near the doorway soiled with feces and the room had a strong feces odor radiating out into the hallway.</p> <p>Interview with the Housekeeper at the time of the observation confirmed the resident had no pants on, legs were exposed, the room had a strong feces odor radiating out into the hallway, and feces soiled pants were laying on the floor.</p> <p>Observation on October 20, 2014, at 4:08 p.m., in the resident's bathroom revealed feces in the toilet, toilet paper soiled with feces on the floor, feces soiled pants on the floor, and the bathroom and bedroom had a foul odor.</p> <p>Interview with the Director of Nursing on October 22, 2014, at 3:00 p.m., in the central supply office confirmed when the resident was seen in the wheelchair and doorway to the room, with no pants, legs exposed, feces soiled pants on the floor, and a strong feces odor radiating out into the hallway, dignity was not provided.</p> <p>Observation with Licensed Practical Nurse (LPN #5) on October 22, 2014, at 10:00 a.m., in the 600 hallway, of the resident's wheelchair revealed dried food and brown liquid on the foot rest holders, and other metal areas on the lower part of the wheelchair, the metal side of the wheel</p>	F 241	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p><u>F 241</u></p> <ol style="list-style-type: none"> <li>On 10/20/14 Resident #192 was assisted by staff to obtain clean clothing, the soiled clothing in the room was removed and housekeeping cleaned room. On 10/20/14 bathroom in Resident #192 room cleaned and all soiled items removed. The room and the bathroom were swept and mopped. On 10/22/14 Resident #192 was assisted to the shower by staff where soiled clothing was removed and care provided. Staff also brought wheelchair to shower room and cleaned thoroughly.</li> <li>On 10/20/14 rounds were made by Nursing Management throughout facility to ensure that all other residents were not affected by this practice. No issues were identified during rounds. Resident #192 was assessed and no changes were noted from his base line.</li> <li>Nursing Staff will be in-serviced by Risk Manager and/or Director of Nursing on Dignity, Respect and Infection control by November 20, 2014. This training will continue to be included in the new hire orientation.</li> <li>Random observations for dignity, respect and infection control will be performed at different times of the day to ensure compliance by the Nursing Supervisors and or Risk Manager (3 audits per week x 4 weeks) Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.</li> </ol>	<p>10/20/14 + 10/22/14  10/20/14  11/26/14  12/6/14</p>

NOV. 14. 2014 4:36PM

HOLSTON MANOR

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NAME OF PROVIDER OR SUPPLIER  <b>HOLSTON MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3641 MEMORIAL BLVD KINGSPORT, TN 37664</b>		
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F 241	Continued From page 4 chair, and both arm rests. Continued observation revealed the resident's jacket with dried food debris on the front and on the sleeve cuffs.	F 241			
F 242 SS=D	Interview with LPN #5 on October 22, 2014, at 10:00 a.m., in the 600 hallway, confirmed dignity was not provided when the resident was left with dried food debris on the clothes and wheelchair. <b>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</b>  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility Work Sheet log, observation, facility policy review, and interview, the facility failed to honor the preferences of one resident (#130) of thirty-eight residents reviewed.  The findings included:  Resident #130 was admitted on November 12, 2010, with diagnoses including Diabetes Mellitus, Late Effects Cerebrovascular Accident, Hemiplegia, Hypertension, and Urinary Incontinence.  Medical record review of the Annual Minimum Data Set assessment dated July 25, 2014,	F 242			

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F 242	<p>Continued From page 5</p> <p>revealed, the resident scored fifteen out of fifteen on the Brief Interview for Mental Status indicating the resident was cognitively intact for daily decision making. Continued review revealed the resident required extensive assistance of two persons for bed mobility and transfers, and was dependent with assistance of one person for bathing.</p> <p>Medical record review of the Social Services note dated November 15, 2010, revealed, "...Significant Life Experiences [continued]...was admitted from home after...family was unable to care for...gets up at 9 am. Goes to bed around 9 -10 pm...showers for bathing in PM [evening]..."</p> <p>Review of the 400 Wing Work Sheet log with the residents' bathing schedules revealed resident #130 had been scheduled for bathing on the dayshift.</p> <p>Review of facility policy, Quality of Life, Accommodation of Needs, revealed, "...1. The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. 2. The resident's individual needs and preferences...shall be evaluated upon admission and reviewed on an ongoing basis..."</p> <p>Interview with the resident on October 20, 2014, at 4:02 p.m., in the resident's room, confirmed the resident had not been getting up in the morning according to personal preferences. Continued interview confirmed the resident gets up around 8:00 a.m., but would prefer not to get up until 9:00 a.m.</p>	F 242	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p><u>F 242</u></p> <ol style="list-style-type: none"> <li>On 10/22/14 Nursing Supervisor reviewed shower preference and preference on what time she would like to get out of bed with Resident #130. Resident's shower scheduled was changed to the evening shift per her request and staff educated on time that resident preferred to be up. Resident #130 Kardex and care plan were updated to reflect these preferences. On 11/7/14 Assistant Director of Nursing reviewed with Resident #130 if here preferences were being met and no issues were identified. Assistant Director of Nursing also reviewed medication times and breakfast time with resident. Resident requested that medication times be left as they were but would like breakfast around 9AM. Dietary Manager was notified and resident will receive breakfast at 9AM. Kardex and Care Plan were updated to reflect these preferences.</li> <li>All residents have the potential to be affected by the same deficient practice. On 10/22/14 Activities Director and Central Supply Clerk interviewed residents for their preferences. No other issues were identified.</li> <li>Staff will be in-serviced on Self Determination-Resident's Right to make choices about aspects of his/her life in facility that are significant to resident by Risk Manager and/or Director of Nursing by November 20, 2014. This training will be added to the new hire orientation and will be reviewed in the 72 hour Care plan meeting for new admissions.</li> <li>Random interviews will be conducted by Nursing Supervisors and or Risk Manager to ensure resident's preferences are being met. ( 5 interviews per week x 4 weeks, 3 interviews per week x 2 weeks, 2 interviews per week x 1 week) Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.</li> </ol>	10/22/14 11/7/14 10/22/14 11/20/14 12/6/14	

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F 242	Continued From page 6 Interview with the resident on October 22, 2014, at 10:25 a.m., in the resident's room confirmed "Usually gets a shower on day shift, but still prefers to shower in the evening, and would prefer to get up in the morning at 9:00 a.m., instead of 8:00 a.m.  Interview with Licensed Practical Nurse #1, on October 22, 2014, at 10:29 a.m., at the 400 hall nurse's station, confirmed the resident usually is awakened around 7:00 a.m., for medication administration, and again between 7:30 a.m., and 8:00 a.m., for breakfast.  Interview with Certified Nursing Assistant (CNA #1) on October 22, 2014, at 10:43 a.m., at the 400 hall nurse's station, confirmed the resident gets up around 7:00 a.m., for the breakfast meal.  Interview with the Social Services Director (SSD) on October 22, 2014, at 3:14 p.m., in the SSD's office, confirmed the resident's preferences had not been addressed for scheduling time to get up in the morning and the resident's preference for bathing. Continued interview confirmed the facility's policy for accommodation of needs had not been implemented.	F 242			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the	F 280			

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F 280	<p>Continued From page 7</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to revise the Care Plan for one resident (#205) of four residents reviewed for Urinary Incontinence of thirty-eight residents reviewed.</p> <p>The findings included:</p> <p>Resident #205 was admitted to the facility on April 22, 2014, with diagnoses including Diabetes, Altered Mental Status, Convulsions, Psychosis, Insomnia, Mental Disorder, Schizoaffective Disease, Urinary Incontinence, and Anxiety State.</p> <p>Medical record review of the Admission Minimum Data Set (MDS) dated April 29, 2014, revealed the resident frequently incontinent.</p> <p>Medical record review of the Quarterly MDS dated July 29, 2014, revealed the resident always incontinent.</p> <p>Medical record review of the Care Plan dated</p>	F 280	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p>F 280</p> <ol style="list-style-type: none"> <li>On 10/21/14 MDS Coordinator corrected care plan for Resident #205 to reflect that resident is always Incontinent.</li> <li>MDS Coordinators will complete 100% review of all care plans to ensure that the bowel and bladder care plan reflects the resident's current status. Review will be completed by November 28, 2014.</li> <li>Resident Assessment Specialist completed in-service with MDS Coordinators on 11/3/14 on Care Planning in Long Term Care per RA1 manual 3.0.</li> <li>Director of Nursing and/or Assistant Director of Nursing will audit 5 charts per week x 4 weeks to ensure that care plan reflects resident current bowel and bladder status. Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.</li> </ol>	<p>10/21/14</p> <p>11/28/14</p> <p>11/3/14</p> <p>12/6/14</p>



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F 280	Continued From page 8 April 30, 2014, revealed "...Resident is frequently incontinent of Bowel/Bladder..."  Medical record review of an updated Care Plan dated August 1, 2014, revealed "...Resident is frequently incontinent of Bowel/Bladder..."  Interview with the MDS Coordinator on October 21, 2014; at 3:00 p.m., at the 100 nursing station confirmed the care plan had not been revised to reflect the resident is always incontinent.	F 280			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to complete a bladder assessment and develop an individualized toileting plan for three residents (#110, #205, #59) of four of thirty-eight residents reviewed.  The findings included:  Resident #110 was admitted to the facility on May	F 315			

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F 315	<p>Continued From page 9</p> <p>29, 2014, with diagnoses including Intracerebral Hemorrhage, Late Effects/Hemiplegia, Dysphagia, Abnormality of Gait, Lack of Coordination, Cerebral Vascular Accident, Neuropathy, Urinary Incontinence, and Osteoporosis.</p> <p>Medical record review of the Admission Minimum Data Set (MDS) dated June 5, 2014, revealed the resident was frequently incontinent (defined as 7 or more episodes of urinary incontinence).</p> <p>Medical record review of the Quarterly MDS dated August 29, 2014, revealed the resident was always incontinent (defined as no episodes of continent voiding).</p> <p>Medical record review of a Bladder Incontinence Evaluation completed on May 29, 2014, revealed the resident incontinent.</p> <p>Review of facility policy, Bladder Management (Retraining) Program, revealed "...Purpose: Retraining programs are appropriate for residents who are able to participate and have the cognitive ability to understand and follow directions/instructions. To restore optimum level of bladder function...Procedure: (12) Develop toileting schedule with the resident's participation. Toileting schedule should be as close to the resident's customary routine as possible, (16) Observe and record the resident's voiding pattern and revise toileting schedule to meet resident's needs. This should be done until a routine is established..."</p> <p>Interview with the Assistant Director of Nursing (ADON) in the 100 nurse's station on October 21, 2014, at 3:45 p.m., confirmed the resident had</p>	F 315	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p><b>F 315</b></p> <ol style="list-style-type: none"> <li>On 10/27/14 Nursing Management completed Bowel and Bladder Assessments on Residents # 110, # 205 and # 59.</li> <li>All residents have the potential to be affected by the same deficient practice: Nursing Management will complete 100% review of all charts to ensure a current bowel and bladder assessment is present and toileting plans will be developed if indicated by November 28, 2014.</li> <li>Staff will be in-serviced on completing bowel and bladder assessments and the use of toileting plans by Director of Nursing and or Assistant Director of Nursing by November 20, 2014. This training will also be added to the new hire orientation.</li> <li>Director of Nursing and/or Assistant Director of Nursing will audit new admission charts in clinical review to ensure that bowel and bladder assessments have been completed and toileting plans started if indicated. In addition Director of Nursing or Assistant Director of Nursing will audit 5 charts per week x 4 weeks to ensure that bowel and bladder assessments are complete and toileting plans started if indicated. Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.</li> </ol>	<p>10/27/14</p> <p>11/28/14</p> <p>11/20/14</p> <p>12/6/14</p>	

NOV. 19. 2014 4:39PM HOLSTON MANOR  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

No. 1339 RINP. 141/03/2014  
**FORM APPROVED**  
**OMB NO. 0938-0391**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445295</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/22/2014</b>
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NAME OF PROVIDER OR SUPPLIER

**HOLSTON MANOR**

STREET ADDRESS, CITY, STATE, ZIP CODE

**3641 MEMORIAL BLVD  
 KINGSFORD, TN 37664**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	<p>Continued From page 10</p> <p>not been assessed for a bladder program and an individualized toileting program had not been developed.</p> <p>Resident #205 was admitted to the facility on April 22, 2014, with diagnoses including Diabetes, Altered Mental Status, Convulsions, Psychosis, Insomnia, Mental Disorder, Schizoaffective Disease, Urinary Incontinence, and Anxiety State.</p> <p>Medical record review of the Admission MDS dated April 29, 2014, revealed the resident frequently incontinent.</p> <p>Medical record review of the Quarterly MDS dated July 29, 2014, revealed the resident always incontinent.</p> <p>Medical record review of a Bladder Evaluation completed on April 22, 2014, revealed the resident incontinent of bladder.</p> <p>Interview with the ADON in the conference room on October 22, 2014, at 2:30 p.m., confirmed the resident had not been assessed for a bladder program, and an individualized toileting program had not been developed.</p> <p>Resident #59 was admitted to the facility on March 3, 2014, with diagnoses including Late Effect Cerebral Infarction, Stroke Syndrome, and History of Left-Sided Hemiparesis.</p> <p>Medical record review of the Physician's Visit Note dated March 4, 2014, revealed, "...62 year old...recently hospitalized with persistent nausea and vomiting...very deconditioned...s/p [status post] CVA [cerebral vascular accident] with left sided weakness and quite debilitated...transferred</p>	F 315		

Nov. 14, 2014 4:39PM  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 HOLSTON MANOR  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1339 PRIP. 15 11/03/2014  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2014
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NAME OF PROVIDER OR SUPPLIER

HOLSTON MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE  
 3841 MEMORIAL BLVD  
 KINGSPORT, TN 37684

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	<p>Continued From page 11            to [name of nursing home] for rehab services and            consider LTC (long term care) placement..."</p> <p>Observation on October 20, 2014, from 11:40            a.m., through 12:45 p.m., revealed resident #59            in the main dining room, seated in a wheelchair,            accompanied by a visitor.</p> <p>Observation on October 20, 2014, at 3:30 p.m., of            the 400 hallway outside of resident #59's room            revealed a strong odor of urine.</p> <p>Interview with Certified Nursing Assistant (CNA)            #1, at the time of the observation, in the 400            hallway revealed, "We just changed [resident            #59]...I can change out the trash bag."</p> <p>Interview with Resident #59 and the visitor (son)            on October 20, 2014, at 3:35 p.m., in the            resident's room revealed the resident was            recently put into the bed with a "lift" after being up            in the wheelchair since "after breakfast."</p> <p>Interview continued and revealed the resident            toileted at home (prior to admission) by standing,            pivoting, and using a bedside commode with            assistance of the son who was also present for            the interview.</p> <p>Medical record review of the Bladder            Incontinence Evaluation dated March 3 2014,            revealed, "...Perception of Need to Void:            Diminished...Daily incontinence episodes (some            control)...Evaluation for Bladder Program            Potential...Plan: 2 hr [hour] bladder maintenance            program."</p> <p>Interview with one Restorative CNA (#3), one            dayshift CNA (#4) and one evening shift CNA            (#5), in the 500 hallway together on October 22,</p>	F 315		

NOV. 14, 2014 4:39PM HOLSTON MANOR  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1339 PRI P. 16 11/03/2014  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445295</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/22/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOLSTON MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3641 MEMORIAL BLVD KINGSPORT, TN 37864</b>	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 12 2014, at 2:45 p.m., revealed the following: resident #59 had not been on a toileting program from admission to the present time; the three CNA's stated the resident's "knees don't always hold" for a stand and pivot transfer; the resident was transferred using a mechanical lift; the bathroom would not accommodate the lift; the facility did not have a sit-to-stand device to support a resident with one-sided weakness to safely transfer; the use of a bedside commode was allowed in the facility; and the resident presently wore an incontinent brief at all times.  Interview with dayshift Licensed Practical Nurse (LPN) #1 and evening shift LPN #8, at the 400 nursing station at 3:25 p.m., on October 22, 2014, confirmed a scheduled toileting program to promote resident #59's bladder continence had not been developed following the March 2014 plan for a "bladder maintenance program."  Interview with the Director of Nursing (DON) at 3:35 p.m., on October 22, 2014, in the DON's office, confirmed Resident #59 had not had the benefit of a toileting program and had a decline in bladder continence.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/22/2014
NAME OF PROVIDER OR SUPPLIER  HOLSTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664		
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F 318	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide rehabilitation services for a contracture for one resident (#59) of thirty-eight resident's reviewed.</p> <p>The finding included:</p> <p>Resident #59 was admitted to the facility on March 3, 2014, with diagnoses including Late Effect Cerebral Infarction, Stroke Syndrome, and History of Left-Sided Hemiparesis.</p> <p>Medical record review of the Physician's Visit Note dated March 4, 2014, revealed, "...62 year old...recently hospitalized with persistent nausea and vomiting...very deconditioned...s/p [status post] CVA [cerebral vascular accident] with left sided weakness and quite debilitated...transferred to [name of nursing home] for rehab services and consider LTC [long term care] placement...Discussion/Summary - OT and PT..."</p> <p>Observation on October 20, 2014, from 11:40 a.m., through 12:45 p.m., revealed resident #59 in the main dining room, seated in a wheelchair, accompanied by a visitor. Observation revealed the resident fed self with the right hand and the visitor wheeled the resident from the dining room.</p> <p>Observation on October 20, 2014, at 3:35 p.m., revealed a contracture of the left hand and non-use of the left arm. Interview with the son at the time of the observation revealed the resident had previously had a splint for the left hand "at home."</p> <p>Observation on October 22, 2014, at 9:30 a.m., at</p>	F 318	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p>F 318</p> <ol style="list-style-type: none"> <li>On 11/12/14 Resident # 59 was evaluated by therapy and picked up on case load.</li> <li>All residents with contractures have the potential to be affected by the same deficient practice. Screens for all residents with contractures were completed by therapy on 11/12/14.</li> <li>Director of Nursing in-serviced Director of Therapy on completing the screen form completely to ensure that all areas are addressed on form on 11/12/14. Director of Therapy will in-service all therapists on completing the screen form correctly by 11/12/14. Director of Nursing in-serviced MDS nurses on 11/12/14 that if change in resident's functional status is noted during MDS review, they will notify Director of Therapy.</li> <li>Director of Nursing and/or Assistant Director of Nursing will review all screen forms for the month at months end to ensure that all forms are completed appropriately. Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.</li> </ol>	11/12/14 11/12/14 11/12/14 12/6/14	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1339 RINP. 1811/03/2014

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/22/2014
NAME OF PROVIDER OR SUPPLIER  HOLSTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 318	Continued From page 14 the doorway of the resident's room, revealed the resident could use the right hand to grasp the contracted left hand and extend the fingers of the left hand out into an open position.  Medical record review of the quarterly Minimum Data Set assessment dated June 2, 2014, revealed "Functional Limitation in Range of Motion" of one side of body for both the upper and lower extremities.  Medical record review of the Care Plan with an initial date of March 12, 2014, and updated August 24, 2014, revealed, "Problem/Need...Hemiparesis/Paralysis...to left side with contracture to left hand."  Interview with the Rehabilitation Director at the 400 nursing station at 3:20 p.m., on October 22, 2014, revealed the resident had been screened on March 5, 2014, and on July 28, 2014, for rehabilitation needs. Continued interview confirmed on the screening record there were twelve areas with a Yes or No response required "if change or limitation" was observed and all these areas were left blank. Further interview confirmed the twelve areas included ADL [activities of daily living], Transfers, and Joint Mobility. Continued interview with the Rehabilitation Director revealed "the resident cannot be touch during a screening...nursing didn't let us know of any needs." Interview confirmed the resident did not receive a Physical Therapy or Occupational Therapy evaluation after admission and the two Rehabilitation Screenings had not identified the contracture of the left hand.	F 318			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

Nov. 25, 2014 1:17PM

holston manor

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 5280 PR.P. 2: 11/03/2014

FURN APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/22/2014
NAME OF PROVIDER OR SUPPLIER  HOLSTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 15</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, and interview, the facility failed to ensure safety was provided during a transfer with a mechanical lift of one resident (#118) of thirty-eight residents reviewed.</p> <p>The findings included:</p> <p>Resident #118 was admitted to the facility on October 15, 2012, with diagnoses including... Senile Dementia, Psychosis, Diabetes with Neuropathy, Congestive Heart Failure, and Stroke Syndrome with Left Sided Hemiparesis.</p> <p>Medical record review of the quarterly Minimum Data Set assessment dated June 6, 2014, revealed the resident scored three of fifteen on the Brief Interview for Mental Status, indicating low cognitive abilities and totally dependent for bed mobility, toileting, and bathing.</p> <p>Medical record review of the Care Plan dated June 5, 2014, revealed, "Problem...Left Sided Hemiplegia R/T [related to] Previous CVA [cerebral vascular accident]...Resident will be transferred by [mechanical lift] with assist of two."</p>	F 323	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p><b>F 323</b></p> <ol style="list-style-type: none"> <li>1. Resident # 118 no longer resides in facility.</li> <li>2. All residents have the potential to be affected by the same deficient practice. All incident reports will be reviewed in clinical meeting to ensure that contributing factors are used in evaluation of root cause of event. CNAs that assisted Resident #118 with hoyer lift will be in-serviced by Director of Nursing regarding Safe Use of Hoyer Lifts with transfers by November 28, 2014.</li> <li>3. Risk Manager and/or Director of Nursing will in-service all nursing staff regarding Safe Use of Hoyer Lifts with transfers by December 6, 2014. Director of Nursing in-serviced Risk Manager on 10/27/14 regarding ensuring that contributing factors are used in the evaluation of root cause of an event. Licensed Nurses will be in-serviced by Risk Manager and/or Director of Nursing on ensuring that contributing factors are used in evaluation of root cause of event by November 20, 2014. This training will also be added to the new hire orientation.</li> <li>4. Director of Nursing and/or Risk Manager will observe staff completing hoyer lift with residents to ensure safe practices are being used. 5 observations per week x 4 weeks. Risk Manager will continue to review all incident reports in clinical meeting to ensure that contributing factors are being used in evaluation of root cause of event. Director of Nursing and/or Assistant Director of Nursing will audit 5 incident reports per week x 4 weeks to ensure that contributing factors are being used in evaluation of root cause. Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.</li> </ol>	<p>7/7/14</p> <p>11/19/14</p> <p>12/14/14</p> <p>11/20/14</p> <p>10/27/14</p> <p>12/6/14</p>	



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445295</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/22/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOLSTON MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3641 MEMORIAL BLVD KINGSPORT, TN 37864</b>	

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F 323	<p>Continued From page 16</p> <p>Medical record review of the Nurse's Note dated June 6, 2014, at 6:30 p.m., revealed, "Throughout day resident frequently c/o [complained of] L [left] arm pain...NP (Nurse Practitioner) in house new orders received...daughter in house notified..."</p> <p>Review of a facility investigation dated June 9, 2014, revealed the investigation had been completed by the Risk Manager Registered Nurse for a fall during a transfer involving resident #118 on June 5, 2014. Review of the investigation revealed the resident was injured during a transfer from the bed to a chair using a mechanical lift. Review of the Narrative section of the investigation revealed, "Set in floor by CNA's...no sign of injury..."</p> <p>Interview with the Licensed Practical Nurse (LPN) #7 by telephone on October 21, 2014, at 6:30 p.m., revealed the LPN's recounting of the June 5, 2014, fall during a transfer for resident #118, coincided with the LPN's previous written statement. Interview confirmed the resident was on the floor when the LPN entered the resident's room.</p> <p>Interview with one of the two Certified Nursing Assistants (CNA) #6, at 6:00 p.m., on October 21, 2014, by telephone revealed the CNA's recounting of the details of the incident included CNA #6 being in charge of the mechanical lift and "...[the resident] was moving the right, good leg up and down as being lowered to the chair...began to slide out of the seat of the chair because of the leg motion...I was trying to get the lift out of the way so [the resident] wouldn't hit it..."</p> <p>Interview with the Director of Nursing (DON) on October 22, 2014, at 10:00 a.m., in the DON's</p>	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>HOLSTON MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3641 MEMORIAL BLVD KINGSPORT, TN 37664</b>		
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F 323	Continued From page 17 office, confirmed the following: The resident had been safely transferred previously with the mechanical lift; the facility's investigation had not identified contributing factors when a transfer with the mechanical lift on June 5, 2014, resulted in the resident on the floor; the resident's agitated movement of the right leg indicated a safe transfer of the resident was in question; and continuing to transfer the resident to a chair contributed to the resident ending up on the floor.	F 323			
F 332 SS=D	C/O #34071 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to administer three of twenty-seven medications without error resulting in a 10.35% (percent) medication error rate.  The findings included:  Resident #198 was admitted to the facility on January 21, 2014, with diagnoses including Dementia with Behavior Disturbance, Depression, and Depressive Psychosis.  Observation on October 21, 2014, at 8:30 a.m., in resident #198's room revealed Licensed Practical Nurse (LPN #3) administered one tablet of	F 332			

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NAME OF PROVIDER OR SUPPLIER  HOLSTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 18</p> <p>Namenda XR 7 mg (milligrams)(antipsychotic medication).</p> <p>Medical record review of the Physician's order dated May 18, 2014, revealed Namenda XR 28 mg by mouth daily.</p> <p>Interview with LPN #3 on October 21, 2014, at 8:30 a.m., at the 600 nurse's desk confirmed resident #198 received 7 mg of Namenda and the Physician's order was for 28 mg resulting in a medication error.</p> <p>Resident #204 was admitted to the facility on April 3, 2014, with diagnoses including Alzheimer's Dementia, Depression, and Anxiety.</p> <p>Observation on October 22, 2014, at 7:40 a.m., in resident #204's room revealed LPN #2 administered one tablet of Namenda XR 7mg.</p> <p>Medical record review of the Physician's order dated July 24, 2014, revealed Namenda XR 28 mg by mouth daily.</p> <p>Interview with LPN #2 on October 22, 2014, at 8:15 a.m., in the 300 hallway confirmed Resident #204 received 7 mg of Namenda, and the Physician's order was for 28 mg resulting in a medication error.</p> <p>Resident #20 was re-admitted to the facility on October 17, 2014, with diagnoses including MRSA (Methicillin Resistant Staphylococcus Aureus, contagious infection), Sepsis (infection in the blood), Anemia, and Hypertension.</p> <p>Observation on October 22, 2014, at 8:10 a.m., in Resident #20's room revealed LPN #2</p>	F 332	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility's compliance with the requirement of participation and continue to provide high quality resident care.</p> <p><u>F 332</u></p> <ol style="list-style-type: none"> <li>On 10/21/14 Nurse #3 reviewed Namenda XR order for Resident # 198. Nurse#3 returned to resident's room and administered 3 additional 7 mg pills to equal the ordered dose of 28mg. On 10/22/14 Nurse#2 reviewed Namenda XR order for Resident #204. Nurse#2 returned to resident's room and administered 3 additional 7 mg pills to equal the ordered dose of 28mg. On 10/22/14 Nursing Supervisor reviewed orders for Resident #20. Medication error report was completed for missed doses of Flagyl. Physician was notified and order received for Flagyl 500mg po q 8 hours x 7 more days. Nursing Supervisor completed assessment of resident and no changes from baseline were noted.</li> <li>All residents are at risk. All residents with orders for Namenda XR 28mg were reviewed on 10/22/14 by the Director of Nursing. Director of Nursing completed MAR to cart audit and medication count and no issues were noted. MARS and medication boxes have been marked to indicate that 4 pills must be given to equal the 28mg dose, 5 rights of Medication Administration in-service provided to Nurse#2 and #3 by Director of Nursing on 10/22/14.</li> <li>Licensed Nurses will be in-serviced on 5 rights of Medication Administration by Risk Manager and/or Director of Nursing by November 20, 2014. This training will continue to be included in new hire orientation.</li> <li>Assistant Director of Nursing and/or Director of Nursing will complete medication pass evaluations with Licensed Nurses (4 nurses weekly x 4 weeks). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.</li> </ol>	<p>10/21/14</p> <p>10/22/14</p> <p>10/22/14</p> <p>11/20/14</p> <p>12/6/14</p>	

NOV. 14. 2014 4:43PM HOLSTON MANOR  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1339 PRI P. 23 11/03/2014  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2014
NAME OF PROVIDER OR SUPPLIER  HOLSTON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 19 administered the resident's morning medications.  Medical record review of the Physician's re-admission orders dated October 17, 2014, revealed an order for Flagyl 500 mg by mouth every eight hours for 10 days (to prevent a fungal infection during antibiotic therapy).  Medical record review of the Medication Administration Record (MAR) dated October 17, 2014, to October 22, 2014, revealed the licensed nurses had failed to administer the Flagyl since the resident's admission (5 days).  Interview with LPN #2 on October 22, 2014, at 8:15 a.m., in the 300 hallway confirmed Flagyl 500 mg was ordered by the physician and was not given resulting in a medication error.	F 332		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure sanitary conditions during food preparation of ground meat for one of one kitchen reviewed.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2014
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NAME OF PROVIDER OR SUPPLIER

HOLSTON MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

3641 MEMORIAL BLVD  
 KINGSFORD, TN 37664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 20</p> <p>The findings included:</p> <p>Observation on October 20, 2014, at 12:10 p.m., in the kitchen, revealed Cook #1 with gloved hands. Continued observation revealed Cook #1 opened the steamer door and placed a pan of ground meat into the steamer. Continued observation revealed Cook #1 placed gloved hands on hips. Continued observation at 12:15 p.m., revealed Cook #1 placed gloved hands in oven mitts, opened the steamer door, and removed the pan of ground meat. Continued observation revealed Cook #1 placed the pan of ground meat on a work table and removed mitts from gloved hands. Continued observation revealed Cook #1, with the same gloved hands, removed the plastic film covering from the ground meat pan, obtained a food thermometer, placed the thermometer in the ground meat, and touched the ground meat with a gloved hand.</p> <p>Review of facility policy, Food Safety, Proper Use of Disposable Gloves, undated revealed "...Door handles and equipment are considered to be contaminated. Wash hands and apply a clean pair before returning to the task..."</p> <p>Interview with Cook #1 on October 20, 2014, at 12:17 p.m., in the kitchen confirmed the contaminated gloves should have been removed, the hands washed, and new gloves applied prior to handling the food thermometer and touching the ground meat.</p> <p>Interview with the Dietary Manager on October 22, 2014, at 9:30 a.m., in the kitchen office confirmed the facility had failed to ensure sanitary conditions in the handling of the ground meat with</p>	F 371	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p><u>F 371</u></p> <ol style="list-style-type: none"> <li>On 10/20/14 Cook #1 was in-serviced by Dietary Manager on facility policy for Food Safety, Proper use of Disposable Gloves and Infection Control.</li> <li>All dietary staff working on evening of 10/20/14 were in-serviced on facility policy for Food Safety, Proper use of Disposable Gloves and Infection Control.</li> <li>Dietary Staff will be in-serviced on Food Safety, Proper use of Disposable Gloves and Infection control by the Risk Manager and/or Dietary Manager by November 20, 2014. This training will continue to be included in new hire orientation.</li> <li>Dietary Manager will complete random observations to ensure that staff are following policy for Food Safety, Proper use of Disposable Gloves and Infection Control (4 audits per week x 4 weeks). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.</li> </ol>	<p>10/30/14</p> <p>10/30/14</p> <p>11/26/14</p> <p>12/4/14</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1339P RINP. 2511/03/2014

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/22/2014
NAME OF PROVIDER OR SUPPLIER  HOLSTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3841 MEMORIAL BLVD KINGSPORT, TN 37664		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 21	F 371			
F 431 SS=D	contaminated gloved hands. 483.60(b), (d), (e) DRUG-RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.  F 431  1. On 10/22/14 Nurse #2 removed expired insulin from medication cart and obtained new bottle. 2. On 10/22/14 Risk Manager, Assistant Director of Nursing and Unit Manager audited all medication carts for expired insulin and no issues were found. 3. Licensed Nurses will be in-serviced on Medication Storage and Handling by Risk Manager and/or Director of Nursing by November 20, 2014. This training will continue to be included in new hire orientation. 4. Risk Manager and/or Assistant Director of Nursing will complete random audits of medication carts to ensure compliance with proper storage and handling (4 audits per week x 4 weeks). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.	10/22/14 10/22/14 11/26/14 12/4/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445295</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/22/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOLSTON MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3641 MEMORIAL BLVD KINGSPORT, TN 37664</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, review of the manufacturer's recommendations, and interview, the facility failed to discard insulin in a timely manner for one medication cart (300 hall) of six medication carts observed.</p> <p>The findings included:</p> <p>Observation of the 300 hall medication cart on October 22, 2014, at 10:56 a.m., with Licensed Practical Nurse (LPN) #2, revealed an opened, multi-dose (10 milliliter) vial of Novolog insulin for resident #58. Continued observation with LPN #2 revealed the insulin had an open date of September 15, 2014, and a discard date of October 12, 2014.</p> <p>Review of the manufacturer's insert, Highlights of Prescribing Information, revealed, "16. How Supplied/Storage and Handling...Vials: After initial use a vial may be kept...for 28 days..."</p> <p>Interview with LPN #2 on October 22, 2014, at 10:56 a.m., at the 300 hall nurse's station confirmed the insulin should have been discarded on October 12, 2014.</p>	F 431			